BEFORE THE
DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

In the Matter of the Application for an Award of Advocacy and Witness Fees of: Legal Services of Northern California, a California corporation dba Health Rights Hotline, Applicant.	**DMHC Decision 10-06-01 June 3, 2010** Application Received Date: February 2, 2010 Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 For 28 CCR § 1300.67.2.2 (Re: Timely Access)

DECISION GRANTING AWARD OF ADVOCACY AND WITNESS FEES TO LEGAL SERVICES OF NORTHERN CALIFORNIA, A CALIFORNIA CORPORATION DBA HEALTH RIGHTS HOTLINE, FOR SUBSTANTIAL CONTRIBUTION TO PROCEEDING CONTROL NOS. 2002-0018, 2005-0203 AND 2008-1579

1. SUMMARY

This decision awards Legal Services of Northern California, a California corporation doing business as Health Rights Hotline ("Health Rights Hotline" or "APPLICANT"), Advocacy and Witness Fees for its substantial contribution to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 of the Department of Managed Health Care ("Department") regarding Timely Access ("proposed regulation"), which became final as set forth at 28 CCR §1300.67.2.2 (the "regulation"). The award represents a decrease from the amount requested in order to not exceed Market Rate, for the reasons stated herein.

2. BACKGROUND OF CONSUMER PARTICIPATION PROGRAM

The Consumer Participation Program (the "Program" or "CPP"), enacted in Health and Safety Code § 1348.9 (the "Statute"), required the Director (the "Director") of the Department to adopt regulations to establish the Program to allow for the award of reasonable advocacy and

witness fees to any person or organization that (1) demonstrates that the person or organization represents the interests of consumers and (2) has made a substantial contribution on behalf of consumers to the adoption of any regulation or to an order or decision made by the Director if the order or decision has the potential to impact a significant number of enrollees.

The Statute requires the regulations adopted by the Director to include specifications for: (1) eligibility of participation, (2) rates of compensation, and (3) procedures for seeking compensation. The Statute specified that the regulations shall require that the person or organization demonstrates a record of advocacy on behalf of health care consumers in administrative or legislative proceedings in order to determine whether the person or organization represents the interests of consumers.

Pursuant to the Statute, the Program regulations were adopted as section 1010 of Title 28 of the California Code of Regulations (the "Regulations"). The Regulations specified:

a. Definitions for the Program, including: "Advocacy Fee," "Compensation," "Market Rate," "Represents the Interests of Consumers," "Substantial Contribution," and "Witness Fees." (§ 1010, subsection (b)).

b. Procedure for a Request for Finding of Eligibility to Participate and Seek Compensation. (§ 1010, subsection (c)).

c. Procedure for Petition to Participate. (§ 1010, subsection (d)).

d. Procedure for Applying For An Award of Fees. (§ 1010, subsection (e)).

3. REQUIREMENTS FOR AWARDS OF ADVOCACY AND WITNESS FEES

3.1. PROCEDURAL REQUIREMENTS

All of the following procedures must be followed and criteria satisfied for a person or organization that represents the interests of consumers to obtain a compensation award:

a. To become a "Participant," the person or organization must satisfy the requirements of either or both of the following by:

(1) Submitting to the Director a Request for Finding of Eligibility to Participate and Seek Compensation in accordance with 28 CCR §1010(c), at any time independent of the pendency of a proceeding in which the person seeks to participate, or by having such a finding in effect by having a prior finding of eligibility in effect for the two-year period specified in 28 CCR § 1010(c)(3).

(2) Submitting to the Director a Petition to Participate in accordance with 28 CCR §1010(d), no later than the end of the public comment period or the date of the first public hearing in the proceeding in which the proposed Participant seeks to become involved, whichever is later (for

orders or decisions, the request must be submitted within ten working days after the order or decision becomes final).

b. The Participant must submit an "application for an award of advocacy and witness fees" in accordance with 28 CCR §1010(e), within 60 days after the issuance of a final regulation, order or decision in the proceeding.

c. The Participant must have made a Substantial Contribution to the proceeding. (Health & Saf. Code § 1348.9(a); 28 CCR § 1010(b)(8)).

d. The claimed fees and costs must be reasonable (Health & Saf. Code § 1348.9(a)) and not exceed market rates as defined in 28 CCR § 1010.

3.2. APPLICANT'S APPLICATION TO PARTICIPATE

On or about January 8, 2004, APPLICANT submitted its Request for Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

By letter dated January 30, 2004, notice was given that APPLICANT was eligible to participate in the CPP and to seek an award of compensation. A finding of eligibility is valid in any proceeding in which a participant's involvement commences within two years of the finding of eligibility. 28 CCP § 1010, subsection (c)(3).

On September 27, 2006, APPLICANT submitted its Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

On or about September 28, 2006, APPLICANT was found and ruled eligible to participate in the CPP and to seek an award of compensation.

On February 23, 2010, APPLICANT submitted its Request for [Renewal] of Finding of Eligibility to Participate and Seek Compensation in the CPP, giving notice that it represents the interests of consumers and of its intent to claim compensation.

By letter dated March 4, 2010, notice of ruling and of finding of renewal of eligibility was given that the APPLICANT was eligible to participate in the CPP and to seek an award of compensation.

On May 3, 2004, APPLICANT submitted its Petition to Participate (Petition) in the Timely Access rulemaking proceeding. In its Petition, APPLICANT estimated its fees to be $7,500.00. In its Petition, APPLICANT stated that, with respect to the Timely Access regulation issues that:

> In the course of assisting individual consumers, the Health Rights Hotline collects data on consumers ability to access necessary care. The Hotline serves both urban and rural areas the four counties of Sacramento, Yolo, Placer and El

> Dorado and we can assist the department in analyzing the impact of proposed health plan changes on enrollees based on the calls we get. The Hotline is one of the few programs in California that can provide this type of information for commercial, Medi-Cal and Medicare enrollees and some of these comparisons may be useful to the Department in its development of these regulations.

On or about June 2, 2004, APPLICANT's Petition to Participate in the Timely Access rulemaking proceeding was approved.

3.3. APPLICATION FOR AWARD OF ADVOCACY AND WITNESS FEES

The regulation became final and effective on January 17, 2010. Within 60 days thereafter (on February 2, 2010), APPLICANT timely submitted its Application for an Award of Advocacy and Witness Fees (Application). 28 CCR § 1010(e)(1).

After the Application was publicly noticed, no objections to the Application were received.

The application for an award of compensation must include (as required by 28 CCR § 1010(e)(2) and (3)):

> "a. A detailed, itemized description of the advocacy and witness services for which the Participant seeks compensation;
> b. Legible time and/or billing records, created contemporaneously when the work was performed, which show the date and the exact amount of time spent[1] on each specific task[2]; and
> c. A description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding as defined in subpart (b)(8), supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence." 28 CCR §1010 (e)(2).

With its Application, APPLICANT submitted a billing specifying the dates of services, a description of each specific task or each activity of advocacy and witness service, identification of the person providing each service, the elapsed time (exact amount of time spent) for each service in quarters (15 minutes) of an hour for attorney advocates and in 0.5 hour or 30 minute increments for non-attorney advocates, the hourly rate requested,[3] and the total dollar amount billed for each task. The total fees requested for work performed by APPLICANT is $42,697.09.

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[1] "...the phrase 'exact amount of time spent' refers either to quarters (15 minutes) of an hour for attorneys, or to thirty (30) minute increments for non-attorney advocates." 22 CCR § 1010(e)(3).

[2] "The phrase 'each specific task,' refers to activities including, but not limited to:

a. Telephone calls or meetings/conferences, identifying the parties participating in the telephone call, meeting or conference and the subject matter discussed;

b. Legal pleadings or research, or other research, identifying the pleading or research and the subject matter;

c. Letters, correspondence or memoranda, identifying the parties and the subject matter; and

d. Attendance at hearings, specifying when the hearing occurred, subject matter of the hearing and the names of witnesses who appeared at the hearing , if any." 28 CCR § 1010(e)(3)a, b, c, and d.

The Hearing Officer finds that the Application of APPLICANT substantially complies with the technical requirements of 28 CCR § 1010(e)(2) and (3).

4. PROCEDURAL HISTORY

The evolution of the Timely Access proceeding consisted of informal stakeholders meetings and three noticed proceedings with three proceeding control numbers identified as follows.

4.1. PROCEEDING CONTROL NO. 2002-0018 – Access to Needed Health Care Services, amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 in title 28, California Code of Regulations

On July 9, 2004, the Department issued a Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and establishing a 45-day comment period from July 9, 2004 to August 23, 2004.

Initially, no public hearing was scheduled on the proposed regulations.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2002-0018, the Department stated that:

> California Health and Safety code sections 1344 and 1346 vest the Director with the power to administer and enforce the provisions of the Act.
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> California Health and Safety Code section 1344 mandates that the Director have the ability to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of this chapter, including rules governing applications and reports, and defining any terms, whether or not used in this chapter, insofar as the definitions are not inconsistent with the provisions of the Act. Furthermore, the Director may waive any requirement of any rule or form in situations where in the Director's discretion such requirement is not necessary in the public interest or for the protection of the public, subscribers, enrollees, or persons or plans subject to this chapter. In addition, the Director may honor requests from interested parties for interpretive opinions.
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> California Health and Safety Code section 1346 vests in the Director the power to administer and enforce the Act, including but not limited to recommending and proposing the enactment of any legislation necessary to protect and promote the interests of plans, subscribers, enrollees, and the public.
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> Health and Safety Code section 1367.03 requires the Department to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. The Director proposes amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 in Title 28, California Code of Regulations to effectuate section 1367.03 by setting forth minimum standards with which health care service plans

[3] Under the PUC Intervenor Compensation Program, the intervenors submit time logs to support the hours claimed by their professionals. Those logs typically note the dates, the number of hours charged, and the issues and/or activities in which each was engaged. D.06-11-009 (November 9, 2006), p. 26.

(plans) shall comply to ensure that enrollees have timely access to needed health care services.

The proposed regulations set access to care standards concerning the availability of primary care physicians, specialty care physicians, hospital care, and other specified health care services to ensure that enrollees have timely access to care.

Amending section 1300.67.2 and adopting sections 1300.67.2.2 and 1300.67.2.3 shall benefit enrollees because it will ensure that plans provide health care services within reasonable proximity of the business or residence of the enrollee including accessible emergency health care services. The regulation clarifies that all services offered by the plan be accessible without delays detrimental to the health of the enrollees and set timelines for routine non-urgent care, urgent care and preventive care. This will ensure that plan enrollees will receive needed health care services within a reasonable timeframe, while not be overburdening the plans or providers.

A Public Hearing on the proposed regulation was scheduled and noticed for, and held on, August 16, 2004.

On August 17, 2004, the Department issued an Amended Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and extending the public comment period for 30 days to September 22, 2004.

The Department requested input regarding the proposed regulations at a stakeholder meeting held on September 13, 2004, in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Notes regarding comments provided at the meeting were included in the record of the proceedings.

On September 15, 2004, the Department issued an Amended Notice of Proposed Rulemaking proposing to amend 28 CCR section 1300.67.2, adopt 28 CCR sections 1300.67.2.2 and 1300.67.2.3, and extending the public comment period for 45 days to November 8, 2004.

The Department requested input regarding the proposed regulations at a stakeholder meeting held on October 20, 2004, in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Notes regarding comments provided at the meeting were included in the record of the proceedings.

On April 1, 2005, the Department issued a notice of a second public comment period for 15 days ending April 22, 2005, regarding the proposed regulation modified as a result of comments received in the prior 85-day comment period.

By letter dated April 19, 2005, the Department gave notice of intention to withdraw the proposed regulations from the proceeding and to propose a revised version of the regulations

pursuant to a new rulemaking proceeding. A formal Notice of Decision Not To Proceed was published on April 29, 2005.

4.2. PROCEEDING CONTROL NO. 2005-0203 -- Timely Access To Health Care Services, adopting section 1300.67.2.2 in title 28, California Code of Regulations

Beginning in October of 2006, the Department invited parties who would be the subject of the proposed regulation to public discussions ("stakeholder meetings") in order to increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45. Stakeholder meetings were held during October and November of 2006.

On January 12, 2007, the Department issued a Notice of Proposed Rulemaking and Notice of Public Hearing proposing to adopt 28 CCR section 1300.67.2.2, establishing a 52-day written comment period from January 12, 2007 through March 5, 2007, and scheduling a public hearing to be held on March 5, 2007.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2005-0203, the Department stated that:

> The Department proposes to adopt section 1300.67.2.2 pursuant to California Health and Safety code section 1367.03, which specifically authorizes the Department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner. Section 1367.03 directs the Department to develop indicators of and standards for timeliness of access to care.
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> AB 2179 (2002) added section 1367.03 of the Health and Safety Code, expressly instructing the Department to develop and adopt regulations to assure timely access to health care. The statute also contained specific requirements for the content of the regulations, including requirements that the regulations establish indicators of timeliness of access to care, adopt standards for timely access to health care services, and specify the manner in which health care service plans are to report annually to the Department on compliance with the standards. Accordingly, the regulation establishes standards and requirements related to: timely access to primary care physicians, specialty physicians, hospital care, and other health care; health plan monitoring of health care provider compliance with the standards; corrective action by health plans upon identifying deficiencies in compliance; and the statutory requirement of filing an annual report of compliance.
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> The statute requires the adoption of "time elapsed" standards specifying the time elapsed between the time an enrollee seeks health care and obtains care. The statute also authorizes the Department to adopt standards other than time elapsed but requires the Department to demonstrate why such standard other than time elapsed is "more appropriate." Proposed section 1300.67.2.2 adopts time elapsed standards and proposes a "same-day access" standard which is demonstrated to be "more appropriate" than time elapsed standards because timeliness of access under the same-

day access standard exceeds timeliness of access under all of the time elapsed standards of the proposed regulation.

In Section 1 of AB 2179, the Legislature found and declared "that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population."

A Public Hearing on the proposed regulation was scheduled and noticed for, and held on, March 5, 2007.

On July 16, 2007, the Department issued a Notice of a Second Public Comment Period for 45 days from July 16, 2007 through August 30, 2007, and Notice of Second Public Hearing for August 13, 2007. By notice dated August 8, 2007, the Department rescheduled the Second Public Hearing to September 18, 2007, and extended the Second Public Comment Period for 21days ending September 21, 2007.

A Public Hearing on the proposed regulation was held on September 18, 2007.

On December 10, 2007, the Department issued a Notice of a Third Public Comment Period for 16 days from December 10, 2007 through December 26, 2007.

On January 11, 2008, the Department submitted the proposed regulation to the Office of Administrative Law ("OAL") for review in accordance with the Administrative Procedure Act ("APA"). On February 27, 2008, the OAL disapproved the proposed regulation, and issued a Decision of Disapproval of Regulatory Action dated March 5, 2008.

4.3. PROCEEDING CONTROL NO. 2008-1579 – Timely Access to Non-Emergency Health Care Services, adopting section 1300.67.2.2 in title 28, California Code of Regulations

In June and September of 2008, the Department invited parties who would be the subject of the proposed regulation to public discussions ("stakeholder meetings") in order to further increase public participation and improve the quality of the proposed regulation. Gov't Code § 11346.45.

On January 9, 2009, the Department issued a Notice of Proposed Rulemaking Action proposing to adopt 28 CCR section 1300.67.2.2, and establishing a 45-day comment period from January 9, 2009 to February 23, 2009.

In the Informative Digest/Policy Statement Overview contained within the Notice of Proceeding Control No. 2008-1579, the Department stated that:

The Department proposes to adopt section 1300.67.2.2 to establish standards and requirements for timely access as required by section 1367.03.

AB 2179 (2002) added section 1367.03 of the Health and Safety Code, directing the Department to develop and adopt regulations to ensure that enrollees have timely access to needed health care services. In Section 1 of AB 2179 the Legislature found and declared "that timely access to health care is essential to safe and appropriate health care and that lack of timely access to health care may be an indicator of other systemic problems such as lack of adequate provider panels, fiscal distress of a health care service plan or a health care provider, or shifts in the health needs of a covered population."

Section 1367.03 contains a number of requirements regarding the development and content of the regulations, including specified factors to be considered by the Department in developing the regulations, requirements for contracts between plans and providers, and annual plan reporting requirements. The proposed regulations have been developed in accordance with the legislative directive set forth in Section 1367.03.

These proposed regulations adopt a balanced approach, to achieve workability and provide for operational flexibility, by establishing both performance standards and prescriptive time-elapsed standards; reasonable mechanisms to preserve the relevance of the clinical judgment of providers, provisions to encourage best practices for enhanced accessibility and a mechanism for enrollees to obtain assistance in determining the relative urgency of their need an appointment. These proposed regulations also strike a reasonable balance with meaningful performance standards for quality assurance monitoring by plans and their delegated provider groups.

Initially, no public hearing was scheduled on the proposed regulations. However, by letter dated January 28, 2009, a representative of the California Medical Association requested that a public hearing be held.

On January 30, 2009, the Department issued an Amended Notice of Rulemaking Action and Public Hearing Agenda. The Public Hearing was scheduled for February 23, 2009.

A Public Hearing on the proposed regulation was held on February 23, 2009.

On June 10, 2009, the Department issued a Notice of Second Comment Period and modified Proposed Text for 15 days from June 10, 2009 through June 25, 2009.

On July 23, 2009, the Department issued a Notice of Third Comment Period and modified Proposed Text for 15 days from July 23, 2009 through August 7, 2009.

On September 28, 2009, the Department issued a Notice of Fourth Comment Period and modified Proposed Text for 15 days from September 28, 2009 through October 13, 2009.

On or about November 3, 2009, the Department issued an Updated Informative Digest for Timely Access to Non-Emergency Health Care Services (2008-1579) as follows:

As required by section 11346.9 of the Government Code, the Director of the Department of Managed Health Care (Director) sets forth below the updates to the Informative Digest

for this rulemaking action proposing the addition of section 1300.67.2.2 to title 28, California Code of Regulations (Regulations).

Authority and Reference

Pursuant to Health and Safety Code section 1341.9, the Department of Managed Health Care Department) is vested with all duties, powers, purposes, responsibilities, and jurisdiction as they pertain to health care service plans (plans) and the health care service plan business.

Health and Safety Code section 1344 grants the Director authority to adopt, amend, and rescind such rules, forms, and orders as are necessary to carry out the provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act).

Health and Safety Code section 1367.03, added to the Knox-Keene Act pursuant to AB 2179, (stats 2002, c. 797) requires the Department to develop and adopt regulations to ensure that enrollees have access to needed health care services in a timely manner by developing indicators of timeliness of access to care and developing standards for timeliness of access.

Health and Safety Code section 1367 establishes significant standards for the delivery and quality of health care services by health plans, including broad requirements for delivering care in a timely manner as appropriate for each enrollee's health care needs, and consistent with good professional practice. Subsection (d) of section 1367 requires that plans "shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice." Prior to the enactment of AB 2179, subsection (e)(1) of section 1367 required that "All services shall be readily available at reasonable times to all enrollees. To the extent feasible, the plan shall make all services readily accessible to all enrollees." AB 2179 amended subsection (e)(1) to require, "All services shall be readily available at reasonable times to <u>each enrollee consistent with good professional practice</u>. To the extent feasible, the plan shall make all services readily accessible to all enrollees <u>consistent with Section 1367.03</u>." (Underline added to reflect the new language added by AB 2179.)

AB 2179 made another notable amendment to section 1367, by adding the following clarification regarding the ultimate obligation of health plans to comply with the standards and requirements of Section 1367, "The obligation of the plan to comply with this section shall not be waived when the plan delegates any services that it is required to perform to its medical groups, independent practice associations, or other contracting entities."

Health and Safety Code section 1367.01, regarding health plan utilization review processes, and Civil Code section 3428, establishing a cause of action for ordinary negligence for a health plan's breach of the duty of ordinary care in performing utilization review, are important provisions relevant to the development of these regulations.

<u>Necessity</u>

Adoption of Section 1300.67.2.2 remains necessary to implement, clarify, and make specific the requirements of Health and Safety Code section 1367.03 (Section 1367.03) as described in the initial Notice of Rulemaking Action published on January 9, 2009. As explained in the Department's Notice of Rulemaking Action and the Initial Statement of Reasons, Section 1367.03 expressly instructs the Department to develop and adopt regulations "to ensure that enrollees have access to needed health care services in a timely manner" and directed the Department to develop indicators of timeliness of access to care including three indicators specified in subsection (a)(1)-(3) of Section 1367.03. Subsection (b) of Section 1367.03 further directs the Department to consider specified factors in developing standards for timeliness of access to care. Subsection (c) of Section 1367.03 permits the Department to adopt standards other than the time-elapsed from the time an enrollee first seeks care and obtains it, if the Department demonstrates why that standard is more appropriate.

AB 2179 also required the California Department of Insurance (CDI) to adopt regulations, although the legislature described a different approach for the CDI than it outlined for the Department. The Department has consulted with CDI regarding the development of these regulations, consistent with Section 1342.4, to assess the potential for consistency in developing the respective regulations.[4]

The course of this rulemaking action has been highly complex and controversial, with interested and affected persons very polarized in their views about the best approach to establish standards for timeliness of access to health care services. The extreme complexity and serious polarization of the interested persons participating in the development of this regulation resulted in the submission of many different alternatives by the interested persons. The alternatives proposed to and considered by the Department are captured in the public comments collected during four public comment periods, and in the Department's responses to each of the public comments.

The final revised regulation text remains true to the legislative intent and mandate reflected in Section 1367.03, while accomplishing the difficult task delegated to the Department by the Legislature, that is, to balance the competing concerns among affected persons, to accomplish sensible, workable and meaningful regulations designed to ensure timely access to care for enrollees. The necessity for the provisions in the final revised text and for the changes made to the text that was initially published, is explained in the Final Statement of Reasons.

The final revised regulation text reflects substantial changes that are sufficiently related to the original text and within the scope of the Notice of Rulemaking Action. Accordingly, consistent with APA requirements, the Department made the revised text

[4] The CDI added geographic accessibility standards (distance metrics) to its existing regulations. The geographic access standards added by the CDI for primary care physicians and hospitals are consistent with the Department's geographic access standards for those categories of services. The CDI also added geographic access standards for specialist physicians and mental health care providers. These regulations do not modify existing Knox-Keene geographic access standards, which do not include standards for specialist physicians and mental health care providers. The Department's approach, as required by Section 1367.03, is directed to address the waiting times for services. Sections 1300.51(d)(Exhibit H), 1300.67.2 and 1300.67.2.1, title 28, California Code of Regulations. Additional consistency between CDI regulations and DMHC regulations may be found in physician-to-enrollee ratio requirements: 1 full time equivalent primary care physician for every 2000 enrollees; and 1 full time equivalent physician for every 1,200 enrollees.

available for public comment. A reasonable member of the directly affected public could have determined from the Notice that these changes to the regulation could have resulted.

On November 3, 2009, the final regulation package was submitted to the Office of Administrative Law (OAL). The regulation was approved by OAL[5] and filed with the Secretary of State on December 18, 2009. The regulation was effective on January 17, 2010.[6]

5. SUBSTANTIAL CONTRIBUTION

Health and Safety Code section 1348.9, subdivision (a) provides that:

> "[T]he director shall adopt regulations to establish the Consumer Participation Program, which shall allow for the director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of any regulation...." (Emphasis added).

The definition of "Substantial Contribution" provides the criteria for evaluating whether the consumer participant has made a substantial contribution.[7] 28 CCR § 1010(b)(8) defines "Substantial Contribution" as follows:

> "'Substantial Contribution' means that the Participant significantly assisted the Department in its deliberations by presenting relevant issues, evidence, or

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[5] Office of Administrative Law, Notice of Approval of Regulatory Action, OAL File No. 2009-1103-04 S, December 18, 2009.

[6] *Id.*

[7] Further guidance is provided in PUC Decisions awarding intervenor compensation – for example:

> "In evaluating whether ... [an intervenor] made a substantial contribution to a proceeding, we look at several things. First, did the ALJ or Commission adopt one or more of the factual or legal contentions, or specific policy or procedural recommendations put forward by the ... [intervenor]? ... Second, if the ...[intervenor's] contentions or recommendations paralleled those of another party, did the ...[intervenor's] participation materially supplement, complement, or contribute to the presentation of the other party or to the development of a fuller record that assisted the Commission in making its decision? ... [T]he assessment of whether the ...[intervenor] made a substantial contribution requires the exercise of judgment.
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> "In assessing whether the ...[intervenor] meets this standard, the Commission typically reviews the record, ... and compares it to the findings, conclusions, and orders in the decision to which the ...[intervenor] asserts it contributed. It is then a matter of judgment as to whether the ..[intervenor's] presentation substantially assisted the Commission. [citing D.98-04-059, 79 CPUC2d 628, 653 (1998)].
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> Should the Commission not adopt any of the ...[intervenor's] recommendations, compensation may be awarded if, in the judgment of the Commission, the ...[intervenor's] participation substantially contributed to the decision or order. For example, if ...[an intervenor] provided a unique perspective that enriched the Commission's deliberations and the record, the Commission could find that the ...[intervenor] made a substantial contribution." PUC Decision D.06-11-031 (November 30, 2006), PP. 5 - 6; similarly, D.06-11-009 (November 9, 2006), pp. 7 - 8.

arguments which were helpful, and seriously considered, and the Participant's involvement resulted in more relevant, credible, and non-frivolous information being available to the Director."

5.1 APPLICATION MUST INCLUDE DESCRIPTION OF CONTRIBUTION

The application for an award of compensation must include "a description of the ways in which the Participant's involvement made a Substantial Contribution to the proceeding [8]..., supported by specific citations to the record, Participant's testimony, cross-examination, arguments, briefs, letters, motions, discovery, or any other appropriate evidence." 28 CCR § 1010(e)(2)c.

5.2. APPLICANT'S DESCRIPTION OF ITS CONTRIBUTION

In its Application, Applicant submitted the following in support of the description of its substantial contribution to the timely access regulation proceeding.

> The Hotline's involvement made a substantial contribution to timely access regulation proceedings. The Hotline has been involved in timely access rulemakings since they began; Hotline staff have consistently commented on timely access regulations and participated in stakeholder groups since 2004. With each iteration of the regulations, the Hotline staff researched other states laws on Timely Access, and current law in California on timely access and other related matters. The Hotline participated in conference calls with other advocates to prepare responses to proposed regulations. The Hotline staff also read through our own client cases that dealt with timely access problems to fully understand where and how problems were occurring and how the proposed regulations would address the problems faced by Hotline callers.
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> The Department published the initial Access to Needed Health Care Services proposed regulation in 2004 and opened a public comment period. The Hotline submitted written comments on the proposed regulation to the Department on November 8, 2004. The Hotline's comments advocated for specified waiting time for triage for urgent care appointment. The finial regulations do specify the waiting time for telephone triage appointments. The Hotline also requested that the regulations incorporate health plans' obligation to provide access to language assistance and culturally appropriate services. The final regulations do include language access. These first comments advocated for setting a global physician-patient ratio limit in addition to the physician-enrollee ratio standard. The Hotline also suggested that the regulations require health plans to have a documented system for monitoring and evaluating provider compliance with the standards. The comments pointed out how the monitoring called for in the regulations was not sufficient. The Hotline based its comments on data

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[8] Decisions under the PUC's Intervenor Compensation Program go further and require intervenor's to assign a reasonable dollar value to the benefits of the intervenor's participation.

> "D.98-04-059 directed ...[intervenors] to demonstrate productivity by assigning a reasonable dollar value to the benefits of their participation to ratepayers. The costs of ...[an intervenor's] participation should bear a reasonable relationship to the benefits realized through their participation. This showing assists us in determining the overall reasonableness of the request." D.06-11-031 (November 30, 2006), p. 11; D.06-11-009 (November 9, 2006), pp. 31 - 32.

gathered from consumers who contacted the Hotline for assistance with Timely Access.

In 2005, the Department released a second version of the Access to Needed Health Care Services regulations. The Hotline submitted a second set of written comments to the Department on April 22, 2005. The Hotline's comments reiterated the issues above as well as advocating for requiring plans to submit a copy of their monitoring systems. These comments also stressed the importance of compliance and ensuring that the Department monitors compliance. Again, the Hotline based its comments on the experience of consumers who had contacted the Hotline for assistance with a timely access problem. The Department withdrew this rulemaking action on April 29, 2005. On June 17, 2005 the Hotline's managing attorney and staff attorney participated in a stakeholder meeting with the Department to discuss the future of timely access regulations.

In January of 2007, the Department released the initial version of the Timely Access to Health Care Services regulation and opened a public comment period which ended on March 5, 2007. The Hotline carefully compared the new version to the implementing statute and to the first and second versions, researched mental health parity laws, and reviewed Hotline data for new information to include in comments to the Department. The Hotline submitted written comments to the Department on March 5, 2007. These comments focused on the inadequate standards proposed for mental health, dental health, and durable medical equipment wait times. The Hotline provided client stories to illustrate why stricter standards were necessary. The final version of the regulations contains stricter time standards than were proposed in the January 2007 version. The Hotline also suggested replacing vague language such as "reasonable time" and "shortest time appropriate" with specific standards. The comments also asked for changes in compliance monitoring and survey methods. A Hotline staff attorney testified at the public hearing in Sacramento on March 5, 2007.

In July of 2007, the Department released a second version of the Timely Access to Health Care Services regulation and opened a public comment period which ended on September 21, 2007. The Hotline submitted comments on September 21, 2007 asking for shorter wait times for dental and mental health appointments. The Hotline also requested that it be specified that the need for an interpreter is not a patient caused delay. A section was included in the final regulation that does specify this in asserting that interpreter services shall be coordinated with scheduled appointments. The Hotline also requested that telephone access time standards apply to all plans and providers regardless of how they answer their calls. This was included in the final regulations. The Hotline again read through many of its own client case that dealt with timely access problems to get an idea of where and how problems were occurring and how the proposed regulations would address the problems faced by Hotline callers. A Hotline staff attorney testified at the public hearing in Sacramento on September 18, 2007.

In December 2007, the Department released a third version of the Timely Access to Health Care Services regulations and opened up a brief public comment period. The Hotline submitted comments opposing these new regulations. We opposed the lack of specific timely access standards and the fact that this new rendition was not significantly related to the last. We also objected to the fact that specialty plans were entirely left out of these regulations. The Hotline again looked to our clients' experiences to inform our comments and researched requirements for notice and comment periods, language access and out-of-network access. The Office of Administrative Law disapproved these regulations on February 27, 2008. The final regulations did go back to specific time standards and to including specialty plans.

From June to September 2008 the Department engaged stakeholders in a lengthy process to shape the future of the timely access regulations. The Hotline participated in all steps of this process including collaborating on written product with the Western Center on Law and Poverty and Health Access and attending and commenting at the stakeholder meetings.

In January 2009, the Department released the initial version of the Timely Access to Non-Emergency Health Care Services regulations. The Hotline submitted comments on February 23, 2009. The Hotline read through the prior versions of the timely access regulations to compare to the newer version. Our comments focused on wait time for dental care, compliance monitoring, and enrollee education. A Hotline staff attorney testified at the public hearing in Sacramento.

On June 10, 2009 the Department put out a second version of the Timely Access to Non-Emergency Health Care Services regulations with a comment period to end on June 25, 2009. The Hotline submitted comments regarding changes to triage sections, and advocating for changes to the out-of-network policies as well as asking for timely access standards to be included in the plans' evidences of coverage.

The Hotline reviewed, but did not comment on the regulations released in July as the changes therein did not appear to affect consumers. The Hotline signed on to the Western Center on Law and Poverty's comments on the final round of comments in October 2009.

Through these activities, the Hotline made a substantial contribution to the Timely Access regulations. The Hotline presented relevant issues, evidence and arguments that were seriously considered by the Department which we believe resulted in more relevant, credible and non-frivolous information being available to the Director.

5.3 PROCEDURAL VERIFICATION OF SUBSTANTIAL CONTRIBUTION

Proceeding Control No. 2002-0018

In preparation for submitting comments, APPLICANT's staff researched other states' laws on timely access as well as California law and participated in conference calls with other advocates to prepare responses to proposed regulations. Importantly, APPLICANT's staff reviewed APPLICANT's client data base to identify client cases that involved timely access problems in order to describe examples of problems involving timely access and whether and how the proposed regulations would address such problems.

By letter dated November 8, 2004, APPLICANT's staff presented written comments signed by a Staff Attorney of APPLICANT on the proposed regulation. That submission contained four comments, including recommendations requesting changes (identified in the order presented in the comment letter):

(1) the regulation should set a standard for physician-enrollee ratio and a global physician-patient ratio limit; and the regulation should require health plans to monitor the total number of patients under the care of plan-contracted physicians to assure compliance with the global limit to help ensure timely access to health care services.

(2) the regulation incorporate more oversight on the method of monitoring and evaluating provider compliance with timely access standards, including requiring that health plans file their proposed monitoring protocol to the Department before the first year in which the are required to file an annual report pursuant to the regulation; that compliance with timely access standards should not be allowed to be demonstrated by using survey results from the current Consumer Assessment of Health Plans Study ("CAHPS") because the CAHPS survey questions do not address specific time periods of the proposed timely access standards and therefore is not a sufficient tool for demonstrating compliance; and that the monitoring protocol should assess whether patients were offered appointments within the standard times.

(3) the proposed regulation should set a specific standard for an enrollee's waiting time to speak to a qualified professional for urgent care appointment triage, including timely access to telephone triage; and that the outer limit for waiting time for a call-back should be four hours.

(4) the proposed regulation incorporate health plans' obligations to provide access to language assistance and culturally appropriate services, give appointments within the prescribed times with an interpreter for limited English proficient patients, and reference the language assistance regulations.

By letter dated April 22, 2005, APPLICANT's staff presented written comments signed by the Acting Program Director/Supervising Attorney of APPLICANT on the proposed regulation.

That submission contained six comments, including recommendations requesting changes (identified in the order presented in the comment letter):

(1) the regulation should reinstate the physician-enrollee ratio requirement of one full-time equivalent provider for each 1,200 enrollees; and that a global ratio be added to ensure that providers contracting with multiple health plans will not have more patients assigned to them than they can effectively and timely serve.

(2) health plans be required to submit their proposed monitoring protocols to the Department for review in advance of the required annual reports regarding monitoring and compliance.

(3) the regulation set a specific waiting time standard for triage by which a provider is expected to return an enrollee's message requesting an urgent appointment, not to exceed four hours; and that a recordkeeping requirement to facilitate effectively monitoring of compliance with timely screening and triage requirements.

(4) the regulation require that if the plan does not have a contracted provider within the timely access standards, then the plan should arrange for the enrollee to see a non-contracted provider for the same co-payment that would apply to a visit with a contracting provider; and that this requirement be included in enrollee disclosures so that enrollees may know the specific avenues they have to timely access needed health care services.

(5) the following factors be added to what the Department will look to in evaluating plan compliance with timely access standards: the extent of non-compliance (e.g., the number of days beyond the timeframe standards specified in the regulation); the adequacy of the plan's monitoring plan; any corrective actions the plan took to remedy its non-compliance, so that a plan that immediately took effective corrective action to remedy non-compliance could be viewed more favorably than a plan that delayed action or adopted ineffective compliance measures; and the extent to which the plan arranged for enrollees to see non-contracting providers when the contracting providers could not meet the standards.

(6) the regulation should address health plans' obligations to provide access to language assistance and culturally appropriate services; and the language assistance code sections and regulations should be referenced in the timely access regulation.

On June 17, 2005, representatives of APPLICANT participated in a stakeholder meeting with the Department to discuss the future of timely access regulations.

Of the November 4, 2004 and April 2005, comments requesting changes, all were reviewed, but all were neither accepted nor declined because the Department issued notice of its decision not to proceed with the rulemaking action of Proceeding Control No. 2002-0018.

On March 5, 2007, a Staff Attorney of APPLICANT testified at a public hearing on the proposed regulation.

By letter dated March 5, 2007, APPLICANT's staff presented written comments signed by a Staff Attorney of APPLICANT on the proposed regulation. That submission contained approximately thirty-one comments, including expressions of support for approximately 15 provisions and presentation of factual situations from APPLICANT's consumer data base illustrating why the provisions were needed. In addition, the submission contained approximately 16 comments containing recommendations requesting changes (identified below in the order presented in the comment letter):

(1) in order to not delay care because of delay in getting test results to physicians, the regulation should include standards specifying time within which routine tests must be performed and standards for the time in which the test results must be sent to the ordering provider.

(2) regarding mental health care accessibility, the regulation should provide for not more than a 24 hour (instead of 48 hour) wait time for an urgent mental health appointment; that electronic communication (telephone and email) should not suffice to meet an urgent mental health need; and that the wait time for routine mental health care appointments should be the same as for routine primary care appointments – i.e., 10 business days and not 24 days for mental health.

(3) the regulation should include a timely access standard for durable medical equipment suppliers in order to avoid negative effect on quality of life and ability to function.

(4) regarding hospital accessibility, "the shortest time appropriate" is too vague a standard to measure routine hospital care, and that standard should be replaced with a specific measurement standard that the Department can use in its compliance monitoring.

(5) the proposed waiting times for routine (42 days), urgent, and preventive (180 days) dental care are too long, and those standards should be replaced with 14 days for routine dental care and 60 days for preventive dental care.

(6) regarding timely telephone access, plans should be required to keep records to show compliance with telephone access standards rather than simply keep records of enrollee complaints; and that a more concrete standard should be added regarding provider response where an answering machine is used, including how to contact a qualified professional for triage when the provider's office uses a recorded message to answer telephone calls.

(7) regarding appointment changes or cancellations, the regulation should contain a standard limiting how many times an appointment can be cancelled, specifying that consumers should be

notified at least 48 hours in advance of a cancelled appointment, and specifying that when an appointment is cancelled, a new appointment should be scheduled at that time.

(8) regarding follow-up or standing appointments, the regulation should specify a concrete standard instead of a broad "good professional practice" standard to assure enrollees receive timely access to follow-up care.

(9) regarding referrals to specialists, the referring provider should be informed when appointments with alternate providers are offered by the plan due to excessive wait time to access the specialist to which the enrollee was referred.

(10) regarding the provision concerning "provider shortage," the standard should refer to "provider availability" in order to avoid lack of timely availability due to a very busy practice, and that the plan should make arrangements for a patient to see an appropriate provider outside the medical group or health plan network to assure timely access.

(11) the regulation should be rephrased to require plans to clearly specify the process that will be used to educate enrollees about their right to timely access to care and the steps an enrollee can take when timely access standards have not been met.

(12) regarding monitoring by plans, the use of non-anonymous phone calls and provider surveys should be stricken because they may not elicit accurate information on actual wait times; and that instead, the plan should use auditing of provider records and secret shopper telephone surveys to most effectively monitor timely access.

(13) regarding enrollee satisfaction surveys, the regulation should require surveys to be in threshold languages as required under the language assistance program regulation.

(14) the proposed regulation specify that the length of time to obtain an interpreter should be included in calculating the overall waiting time standards.

(15) the provision specifying that the proposed regulation does not add any new cause of action should specify that the regulation is not taking away any existing causes of action or rights.

(16) the provision regarding alternative monitoring and reporting be removed because being able to skip a year of monitoring would preclude the Department from becoming aware of a timely access problem until the following year, after the enrollee has been deprived of timely access and perhaps suffered serious health consequences.

On September 18, 2007, a Staff Attorney of APPLICANT testified at a public hearing on the proposed regulation.

By letter dated September 21, 2007, APPLICANT's staff presented written comments signed by a Staff Attorney of APPLICANT on the proposed regulation. That submission contained

approximately twenty-one comments, including expressions of support for approximately seven provisions and presentation of factual situations from APPLICANT's consumer data base illustrating why the provisions were needed. In addition, the submission contained approximately 12 comments containing recommendations requesting changes (identified below in the order presented in the comment letter):

(1) the waiting times for dental care are too long and should be shortened; urgent dental care should be provided within 24 hours, routine care should be provided within 14 days (instead of 36 days), and preventive care should be provided within 60 days (instead of 180 days).

(2) the waiting time for urgent mental health care should be within 24 hours; 48 hours is too long for someone with an urgent mental health need to have to wait).

(3) telemedicine should not supplant in-person appointments, especially where the medical issue needs to be closely examined; a consumer should be able to decline a telemedicine appointment in favor of an in-person appointment and still have the in-person appointment offered in a timely manner.

(4) waiting time should not be extended due to "delay caused by the enrollee" where there is need find an interpreter or make other needed accommodations, to ensure that there is no conflict with the Language Assistance regulations.

(5) regarding telephone access to a qualified professional within 15 minutes during office hours, the exception in the circumstance that a professional is not immediately available should be deleted to avoid the standard being circumvented due to professionals never being available; the regulation should specify a time within which the professional will return the call, such as 30 minutes.

(6) if a provider uses an answering machine, the regulation should specify a specific time within which the call must be returned.

(7) the regulation should require that providers and plans have an after hours access system.

(8) language regarding office waiting times should use the term "standards" instead of "guidelines" to avoid becoming unenforceable; the term "guideline" should be replaced with the word "standard."

(9) to effectively monitor timely access compliance, plans should be required to conduct anonymous as well as non-anonymous telephone surveys; anonymous surveys would remove the incentive to bend the truth; secret shopper surveys should be used in lieu of non-anonymous surveys, and audit of providers' records should be conducted.

(10) to ensure that beneficiaries know specifically when they should be getting access to appointments and how then can go about complaining, the plans' EOCs should list the specific times in which consumers must be able to access appointments as well as telephone and office wait times; these times should be posted in all providers' offices and played on provider and plan recordings during telephone wait times.

(11) preferred provider organizations should be subject to compliance with the timely access regulation standards, so that enrollees in PPOs will receive timely access.

(12) regarding enrollee satisfaction surveys, the regulation should require that all plans use standardized, jointly prepared questions and delete the option of creating their own individual questions, to encourage data aggregation and achieve comparability.

By letter dated December 26, 2007, APPLICANT's staff presented written comments signed by a Staff Attorney of APPLICANT on the proposed regulation. APPLICANT expressed concern that a new version of the proposed regulations did not contain detailed timeliness standards and passed the responsibility for timely access on to the plans "relying on a health plan to come up with their own timely standards, adhere to them, and reveal them to clients...," which APPLICANT termed as "not reasonable." APPLICANT's submission contained approximately twelve comments, including the following (identified in the order presented in the comment letter):

(1) the new proposed regulation would keep things just as they are currently, with health plans in control of when beneficiaries get care and beneficiaries suffering the consequences.

(2) the new proposed regulation does not provide detailed timeliness standards that were in the past two versions of the proposed regulation.

(3) the Department has taken § 1367.03, which requires adoption of regulations "to ensure that enrollees have access to needed health care services in a timely manner," and passed that responsibility on to the plans; the Department's actions do not fulfill the requirements of § 1367.03 and only have placed the onus of the regulations on the plans; the statute clearly placed the responsibility of developing timely access standards upon the Department, and that responsibility cannot be passed on to the plans.

(4) the new proposed regulation does not ensure that enrollees will receive timely access to health care, but simply requires the plans to create their own standards based on vague professional standards which do not currently provide timely access.

(5) in the newly proposed regulation, the Department has so weakened proposed monitoring of compliance with the plans' self-made standards that there will be no valid way to show if the plans are adhering to their own standards.

(6) the result of health plan development of standards will have a number of negative consequences, including: beneficiaries who switch from one plan to another will encounter differing standards of care along the way, and there will be ineffective compliance monitoring.

(7) the Department should go back to a system of specific timely access standards based on urgency and specialty, as well as return to an effective version of compliance monitoring so consumers actually receive timely access to care.

(8) all 20 pages of the prior proposed regulation were cut out and the 7 pages of the new proposed regulation were "almost entirely brand new;" these major and significant changes were not "sufficiently related to the original text so that the public was adequately placed on notice that the changes could result from the originally proposed regulatory action ... as Gov. Code § 11346.8(c) requires." "The Department must publish a new notice with a 45 day comment period."

(9) the proposed regulation should apply to dental, vision, chiropractic, acupuncture, and EAP plans, as in the prior version of the proposed regulation.

(10) office waiting time should be added back as an indicator of timeliness.

(11) the proposed regulation should expressly state that time to acquire interpreters, or serve Limited English Proficient beneficiaries equally in any, must be included in the plans' time standards.

(12) the proposed regulation should state that if another in-network provider is not available in a timely manner, the beneficiary will be referred to an out-of-network provider and the plan will pay for that provider's care.

Of the March 5, 2007, September 21, 2007, and December 26, 2007, comments requesting changes, all were reviewed, but all were neither accepted nor declined because the OAL by decision dated March 5, 2008, disapproved the newly proposed regulation, and the Department did not proceed further with the rulemaking action of Proceeding Control No. 2005-0203.

From June to September 2008, representatives of APPLICANT participated in stakeholder meetings to help shape the future of the timely access regulations.

Proceeding Control No. 2008-1579

In February 2009, APPLICANT's Staff Attorney testified at a public hearing on the latest edition of the proposed regulations.

By letter dated February 23, 2009, APPLICANT's staff presented written comments signed by a Staff Attorney of APPLICANT on the proposed regulation. That submission contained approximately fifteen comments, including expressions of support for revised provisions including commendation for adding back time-elapsed standards, and presentation of factual situations from

APPLICANT's consumer data base illustrating why the provisions were needed. In addition, the submission contained approximately eight comments containing recommendations requesting changes (identified below in the order presented in the comment letter):

(1) recommended language was provided for insertion to clarify that interpreter requirements do not extend the time-elapsed standards.

(2) recommended language was provided to ensure that providers not only have the ability to comply with the time-elapsed standards but actually do comply by offering appointments within the timeframes.

(3) all urgent care, including medical, dental, mental health and ancillary health, should be available within 24 hours, not 48 hours which would put patients at risk, increase likelihood that their conditions will worsen without treatment, and force patients to access care from an emergency department.

(4) recommended language was provided to cover where time for an urgent dental appointment may be extended if the provider or triage person determines and documents that a longer waiting time will not have a detrimental impact on the health of the enrollee.

(5) a provision should be added to ensure that an enrollee may receive out-of-network care when an in-network provider is not available for timely care; such care should cost the enrollee no more than in network care; and the plan should deal directly with the out-of-network provider to arrange for payment for the services.

(6) regarding compliance monitoring, plans should be required to conduct anonymous telephone surveys (to remove the incentive to bend the truth), non-anonymous telephone surveys, and secret shopper calls; and all plans should be monitored and report on the results in the same way to make the results easily understandable by consumers.

(7) on enrollee identification cards and EOCs, the telephone number to access triage and screening services should be provided in the enrollee's preferred language.

(8) the regulation should not allow plans to develop alternative standards to time-elapsed standards.

By letter dated June 25, 2009, APPLICANT's staff presented written comments signed by a Staff Attorney of APPLICANT on the proposed regulation. That submission contained approximately four comments (and incorporated by reference prior comments in prior comment letters), as follows (identified in the order presented in the comment letter):

(1) the time standard of 48 hours for urgent care appointments is too long.

(2) the timely access standards for primary care should specify that if an enrollee cannot secure an timely appointment with their primary care physician or another plan-contracted general practitioner, then the plan should be obligated to arrange for, at no additional cost to the enrollee, an out of network primary care provider.

(3) a 30 minute wait time for triage is too long to be safe or effective. Patients call triage and screening services to determine if their ailment is something that requires immediate emergency room care or if major harm will not result if they wait for an appointment. In 30 minutes, someone experiencing an emergency could suffer dire consequences. If only experiencing an urgent need, the enrollee could, out of fear, seek unnecessary emergency room resources at cost to the enrollee. The maximum acceptable triage wait time should be 10 minutes. In addition, triage services should apply to dental providers so that when the dental provider cannot provide the triage and screening service, then the dental plan should step in and fill that roll for dental enrollees.

(4) plans should be required to include timely access standards in their evidence of coverage documents; not including timely access standards in EOCs would be missing an essential component of enrollees' rights under the plan.

Of the February 23, 2009 and June 25, 2009, comments requesting changes, all were reviewed, some were accepted , some were declined, and some were neither accepted nor declined. The rulemaking action of Proceeding Control No. 2008-1579 resulted in the regulation being filed with the Secretary of State to become effective.

5.4. FINDING OF SUBSTANTIAL CONTRIBUTION

The Hearing Officer finds that participation by APPLICANT: (1) significantly assisted the Department in its deliberations by presenting relevant issues, evidence, and arguments that were helpful and seriously considered, and (2) resulted in more relevant, credible, and non-frivolous information being available to the Director to make her decision regarding the proposed adoption of 28 CCR §1300.67.2.2 than would have been available to the Director had APPLICANT not participated.

The Hearing Officer hereby determines that by its participation APPLICANT made a substantial contribution on behalf of consumers to the proceedings, to the Department in its deliberations, and as a whole, to the adoption of 28 CCR §1300.67.2.2.

The Hearing Officer finds that APPLICANT has made a Substantial Contribution, pursuant to 28 CCR § 1010(b)(8), to the Timely Access rulemaking proceeding.

6. REASONABLENESS OF HOURS AND COSTS AND MARKET RATE

Health and Safety Code section 1348.9 allows the Director to award reasonable advocacy and witness fees to any person or organization that demonstrates that the person or organization represents the interests of consumers and has made a substantial contribution on behalf of consumers to the adoption of a regulation.

6.1. FEES AND COSTS REQUESTED

APPLICANT billed the following time, hourly rates, and fees for its representatives.

Staff / Title	Hours	Rates	Fees
Program Manager			
-- Work in 2004	0.77	$325.00	$250.25
-- Work in 2005	0.0		
-- Work in 2006	7.5	$350.00	$2,625.00
-- Work in 2007	7.5	$350.00	$2,625.00
-- Work in 2008	0.0		
-- Work in 2009	0.0		
Managing Attorney			
-- Work in 2004	0.0		
-- Work in 2005	0.0		
-- Work in 2006	0.0		
-- Work in 2007	0.3	$345.00	$103.50
-- Work in 2008	0.0		
-- Work in 2009	1.5	$365.00	$547.50
Supervising Attorney			
-- Work in 2004	0.75	$260.00	$195.00
-- Work in 2005	8.12	$270.00	$2,192.40
-- Work in 2006	0.0		
-- Work in 2007	0.0		
-- Work in 2008	0.0		
-- Work in 2009	0.0		
Staff Attorney & Policy Analyst #1			
-- Work in 2004	15.77	$170.00	$2,680.90
-- Work in 2005	0.0		
-- Work in 2006	0.0		
-- Work in 2007	0.0		
-- Work in 2008	0.0		
-- Work in 2009	0.0		
Staff Attorney & Policy Analyst #2			
-- Work in 2004	0.0		
-- Work in 2005	3.0	$150.00	$450.00
-- Work in 2006	7.36	$195.00	$1,435.20
-- Work in 2007	0.0		
-- Work in 2008	0.0		
-- Work in 2009	0.0		
Staff Attorney & Policy Analyst #3			
-- Work in 2004	0.0		

-- Work in 2005	0.0		
-- Work in 2006	0.0		
-- Work in 2007	67.95	$200.00	$13,590.00
-- Work in 2008	57.4	$205.00	$11,767.00
-- Work in 2009	17.5	$242.00	$4,235.00
TOTAL FEES[9]	→		**$42,696.75**

APPLICANT did not claim or bill for any expenses or recoverable costs.

6.2. CONSIDERATIONS USED IN PUC'S INTERVENOR COMPENSATION PROGRAM

Reference to the intervenor compensation program of the California Public Utilities Commission ("PUC") seems appropriate because it is similar to the Department's Consumer Participation Program[10] and has an extensive history of awarding intervenor compensation and updating hourly rates used in computing awards of compensation to intervenors who make substantial contributions to PUC decisions.

In each proceeding before the PUC in which intervenors participate, the PUC issues a written opinion setting forth the decision regarding award of intervenor compensation. Therefore, the many PUC written decisions granting intervenor compensation provide a valuable source of guidelines to determine reasonableness and market value. Some of the common threads of the PUC decisions are summarized as follows.

In considering an intervenor organization's request for compensation, the PUC opinions:

a. Separately consider and approve the individual hourly rate of compensation for each of the intervenor's experts and advocates.[11]

b. Have awarded the same rate for an individual expert that was approved in a prior proceeding in the same year,[12] and have declined to approve a requested increase in hourly rate for an expert over the rate approved in a prior proceeding in the same year.[13]

c. Have awarded increases of three percent (3%) rounded to the nearest $5 over the prior year when increase in hourly rates is requested by the intervenor organization or where the hourly rate for an individual expert or advocate was approved in the prior year and an increase is

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[9] APPLICANT's Application contained a computation error resulting in a claim of $.34 more than the hours claimed multiplied by the hourly rate claimed, which is the computation used herein.

[10] The Legislative history behind the Department's Consumer Participation Program specifically referred to the PUC's program.

> "The Legislature finds and declares that consumer participation programs at the Public Utilities Commission and the Department of Insurance have been a cost-effective and successful means of encouraging consumer protection, expertise, and participation...." Stats 2002 C. 792 § 1 (SB 1092).

[11] PUC Decision (D.) 06-11-031 (November 30, 2006).

[12] D.06-11-031 (November 30, 2006).

considered warranted for the current year.[14] The PUC has consistently rejected requests for increase over 3%.[15]

d. Have stated that documentation of claimed hours by presenting a daily breakdown of hours accompanied by a brief description of each activity, reasonably supported the claim for total hours.[16]

e. Have approved compensation for travel time at one-half the normal hourly rate.[17]

f. Have approved compensation for preparation of the intervenor organization's compensation request or compensation claim at one-half the normal hourly rate.[18] However, administrative costs are considered non-compensable overheads, and therefore, the PUC has disallowed time charged by an intervenor's office manager for gathering expense data for the compensation claim.[19]

g. Have approved compensation for efforts that made a substantial contribution even where the PUC did not wholly adopt the intervenor's recommendations.[20]

h. Have approved payment of itemized direct expenses where the request shows "the miscellaneous expenses to be commensurate with the work performed," including costs for photocopying, FAX, Lexis research, postage, courier, overnight delivery, travel, and parking.[21]

i. Have reminded intervenors of the requirements for records and claim support, and that PUC staff may audit the records – for example:

> "We remind all intervenors that Commission staff may audit their records related to the award and that intervenors must make and retain adequate accounting and other documentation to support all claims for intervenor compensation. [Intervenor's]... records should identify specific issues for which it requested compensation, the actual time spent by each employee or consultant, the applicable hourly rate, fees paid to consultants, and any other costs for which compensation was claimed."[22]

j. Have disallowed time where the "hours seem excessive" or the "proposal is not persuasive,"[23] and have changed or disallowed compensation amounts requested for the following reasons:[24] "Excessive hourly rate; arithmetic errors; failure to discount comp prep time [and travel

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[13] D.06-11-032 (November 30, 2006), pp. 10 – 11.
[14] D.06-11-031 (November 30, 2006), p. 11.
[15] D.06-11-031 (November 30, 2006), p. 11.
[16] D.06-11-031 (November 30, 2006), p. 10.
[17] D.06-11-031 (November 30, 2006); D.06-11-032 (November 30, 2006), p. 8, fn. 4.
[18] D.06-11-031 (November 30, 2006), p. 9, fn. 2; D.06-11-032 (November 30, 2006), p. 8, fn. 4.
[19] D.06-11-009 (November 9, 2006), p. 27.
[20] D.06-11-031 (November 30, 2006), p. 10.
[21] D.06-11-031 (November 30, 2006), p. 12; D.06-11-032 (November 30, 2006), pp. 14 – 15; D.06-11-009 (November 9, 2006), p. 32.

time]; hours claimed after decision issued; ...administrative time not compensable; unproductive effort."

6.3. REASONABLENESS OF TIME BILLED

We must assess whether the hours claimed for the consumers' efforts that resulted in substantial contributions to the proceedings are reasonable by determining to what degree the hours and costs (if any costs are claimed) are related to the work performed and necessary for the substantial contribution.[25]

a. Billed Activities. APPLICANT billed for 13 activities summarized as follows:

(1) Review and analysis of the Notice of Proposed Rulemaking and the text of the proposed regulation, legal research regarding timely access law, and preparation of written comments submitted in the written comment period ending November 8, 2004, for a total of 17.29 hours.

(2) Analysis of the text of the proposed regulation, and preparation of written comments submitted in the written comment period ending April 22, 2005, for a total of 3.86 hours.

(3) Review documents, preparation for, and participate in, meeting at DMHC on June 17, 2005, regarding approach to the proposed regulation, for a total of 7.26 hours.

(4) Review documents, review revised proposed regulation, and research and prepare client examples of timely access waiting times and timely access problems, in preparation for participation in, and participate in, stakeholders' meeting at the DMHC on October 24, 2006, and after the stakeholders' meeting, provide information to DMHC regarding waiting times and Medi-Cal contract standards regarding timely access, for a total of 14.86 hours.

(5) Preparation for, attend and provide testimony at, the Public Hearing held on March 5, 2007, for a total of 9.36 hours.

(6) Analysis of the text of the revised proposed regulation, and preparation of written comments submitted in the written comment period ending March 5, 2007, for a total of 22.39 hours.

(7) Preparation for, attend and provide testimony at, the Public Hearing held on September 18, 2007, for a total of 11.13 hours.

(8) Analysis of the text of the revised proposed regulation, and preparation of written comments submitted in the written comment period ending September 21, 2007, for a total of 19.57 hours.

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[22] D.06-11-031 (November 30, 2006), pp. 14 -15.
[23] D.06-11-032 (November 30, 2006), pp. 9 - 10.
[24] D.06-11-009 (November 9, 2006), Appendix p. 1.

(9) Analysis of the text of the revised proposed regulation, and preparation of written comments opposing the revised regulation, submitted in the written comment period ending December 26, 2007, for a total of 5.8 hours.

(10) Review documents, review revised proposed regulation, and prepare proposal language, in preparation for participation in, and participate in, stakeholders' meetings at the DMHC on June 30, and September 3, 4, 10 and 11, 2008, for a total of 56.78 hours.

(11) Preparation for, attend and provide testimony at, the Public Hearing held on February 23, 2009, for a total of 3.0 hours.

(12) Analysis of the text of the revised proposed regulation, and preparation of written comments submitted in the written comment period ending February 23, 2009, for a total of 15.62 hours.

(13) Analysis of the text of the revised proposed regulation, and preparation of written comments in a two-page letter submitted in the written comment period ending June 25, 2009, for a total of 1.0 hour.

b. Finding. The Hearing Officer hereby finds that the time billed is related to the work performed, necessary for the substantial contributions made, and reasonable for the advocacy and witness services performed and work product produced.

6.4. MARKET RATE

Public interest attorneys are entitled to request the prevailing market rates of private attorneys of comparable skill, qualifications and experience. (*Serrano v. Unruh* ("*Serrano IV*") (1982) 32 Cal.3d 621.). APPLICANT is entitled to be compensated for Advocacy Fees and Witness Fees at hourly rates that reflect Market Rate for services. Advocacy Fees and Witness Fees cannot exceed Market Rate, as defined in the Regulation. 28 CCR §§ 1010(b)(1), (3) and (10). "Market Rate" is defined at 28 CCR section 1010(b)(3) as follows:

> "'Market Rate' means, with respect to advocacy and witness fees, the prevailing rate for comparable services in the private sector in the Los Angeles and San Francisco Bay Areas at the time of the Director's decision awarding compensation for attorney advocates, non-attorney advocates, or experts with similar experience, skill and ability."

6.5. HOURLY RATES THAT REFLECT "MARKET RATE"

The Hearing Officer finds that hourly rates for services provided in a statewide proceeding or proceeding of a state agency having statewide jurisdiction and effect (such as proceedings of the

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[25] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 9; D.06-11-009 (November 9, 2006), p. 26.

PUC, see *infra*) are essentially equivalent to "comparable services in the private sector in the Los Angeles and San Francisco Bay Areas," as required by 28 CCR § 1010, subsection (b)(3).

Accordingly, we must take into consideration whether the claimed fees and costs (if any) are comparable to the market rates paid to experts and advocates having comparable training and experience and offering similar services.[26] In order to determine Market Rate, we must look to available data inside and outside the Department.

6.6. APPLICANT'S JUSTIFICATION FOR RATES BILLED

In support of the hourly fee rates requested, APPLICANT submitted experience and biographical information regarding the persons providing services and the following:

The Program Manager had more than 25 years of experience in health and human services advocacy and justification for hourly rates was based on PUC rate range determinations applicable to non-attorney experts. Justification for the rate for 2004 was the result of "working backwards" based on the differences between PUC rate ranges for 2006, 2007 and 2008.

The Managing Attorney had eight years of experience primarily in supervisory and managerial positions. Justification for rates was based on PUC rate ranges for attorneys with 8 – 12 years of experience. The claimed rate for 2009 services was based on PUC rates for 2008 increased by an assumed PUC COLA of three percent (which was not valid because the PUC did not apply a COLA to derive 2009 rates).

The Supervising Attorney had six years of experience in 2004 and acted in a supervisory role. Justification for the rates for 2004 and 2005 was the result of "working backwards" based on the differences between PUC attorney rate ranges for 2006, 2007 and 2008.

The Staff Attorney & Policy Analyst #1 had two years of experience, and the hourly rate for 2004 services was the result of "working backwards" based on the PUC attorney rate ranges for 2006, 2007 and 2008.

The Staff Attorney & Policy Analyst #2 had two years of experience and services performed in 2005 were provided before this Staff Attorney was admitted to the California State Bar. The hourly rate for 2005 services was based on a previous award for this representative's services. Hourly rate for services provided in 2006 was based on the PUC rate range for attorneys with 0 – 2 years of experience.

The Staff Attorney & Policy Analyst #3 had one to two years of experience, and the hourly rates for 2007 and 2008 services were based on the PUC attorney rate ranges for 2007 and 2008. The claimed hourly rate for 2009 services was based on PUC rates for 2008 increased by an assumed

[26] See, e.g., PUC D.06-11-031 (November 30, 2006), p. 10; D.06-11-032 (November 30, 2006), p. 10.

PUC COLA of three percent (which was not valid because the PUC did not apply a COLA to derive 2009 rates).

6.7. HOURLY RATE DETERMINATIONS UNDER THE PUC PROGRAM

A PUC Decision[27] provided the following examples of "recently adopted non-attorney rates and years of professional experience" (as provided by an expert seeking a rate increase), for non-attorney experts.

Non-attorney Hourly Rates

Experience (years)	Year Work Performed	Hourly Rate
16	2003	$215
12	2005	$130
12	2003-2005	$180
5	2005	$120
7	2005	$120
12	2005	$150
8	2005-2006	$150

Until PUC Decision R.04-10-010 in 2004, the PUC "set hourly rates piecemeal"[28] for intervenors – i.e., "... for each proceeding, each intervenor, and indeed each appearance by a particular representative of an intervenor, ...[the PUC] might revisit the reasonableness of that representative's hourly rate."[29] The PUC recognized the need for coordination by establishing, through periodic rulemakings, the rates to be paid to all intervenors' representatives for work done in specified time periods.[30] The first such rulemaking was R.04-10-010. D.05-11-031, which set certain guidelines, recognized that hourly rates had stabilized, and determined that the PUC would not authorize a general increase to intervenor hourly rates for work performed in 2005.[31]

In an Interim Opinion on Updating Hourly Rates,[32] the PUC adopted a three percent (3%) cost-of-living adjustment (COLA) for work performed in calendar year 2006, adopted an additional 3% COLA for work performed in 2007, and established effective with 2007 work three rate ranges for non-attorney experts based on levels of experience, similar to the five levels already established

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[27] D.06-11-032 (November 30, 2006), pp. 11 – 12.
[28] PUC Order Instituting Rulemaking R.06-08-019 (August 24, 2006), p. 2.
[29] *Id.*
[30] *Id.*
[31] *Id.* at pp. 2-3.
[32] D.07-01-009 (January 11, 2007) (part of Rulemaking R.06-08-019).

for attorneys.[33] The three levels for non-attorney experts are: 0-6 years; 7-12 years; and 13-plus years. In so doing, the PUC found that:

> "...basing expert rates on levels of experience, similar to the levels established for attorneys, will better ensure that an expert's given rate is within the market rates paid to persons of comparable training and experience. However, in no event should the rate requested by an intervenor exceed the rate billed to that intervenor by any outside consultant it hires, even if the consultant's billed rate is below the floor for a given experience level. ...[I]ntervenors must disclose the credentials of their representatives in order to justify the requested rates.[34] (Emphasis added).

The following table shows the PUC's adopted ranges for work performed by intervenor representatives in 2006, 2007, 2008 and 2009. The rate ranges for attorneys and non-attorney experts are based on levels of applicable experience.

Hourly Intervenor Rate Ranges for 2006, 2007, 2008[35] and 2009

(2006 rates = rates adopted in D.05-11-031 x 3%, rounded to nearest $5)
(2007 rates = rates adopted for 2006 in D.07-01-009 x 3%, rounded to nearest $5)
(2008 rates = rates adopted for 2007 x 3%, rounded to nearest $5)
(2009 rates = 2008 rates adopted for 2009 in Resolution ALJ-235[36])

Years of Experience	2006 Range	2007 Range	2008 Range	2009 Range
Attorneys:				
0 - 2	$140 - $195	$145 - $200	$150 - $205	$150 - $205
3 - 4	$190 - $225	$195 - $230	$200 - $235	$200 - $235
5 - 7	$260 - $280	$270 - $290	$280 - $300	$280 - $300
8 - 12	$280 - $335	$290 - $345	$300 - $355	$300 - $355
13+	$280 - $505	$290 - $520	$300 - $535	$300 - $535
Experts:				
0 - 6		$120 - $180	$125 - $185	$125 - $185
7 - 12		$150 - $260	$155 - $270	$155 - $270
13+		$150 - $380	$155 - $390	$155 - $390
All years	$115 - $370			

[33] *Id.* at pp. 1, 3-4.
[34] *Id.* at p. 5.
[35] D.08-04-010 (April 10, 2008) (part of Rulemaking 06-08-019) at p. 5.
[36] For work performed in 2009, the PUC ordered that intervenors are not authorized an hourly rate COLA, and hourly rate ranges adopted for 2008 remain in effect. Resolution ALJ-235 (March 12, 2009) at pp. 2-4.

Note: The rates intervenors request for the use of outside consultants may not exceed the rates billed to the intervenors by the consultants, even if the consultants' rates are below the floor for any given experience level.

The PUC decided to continue to update hourly rates annually on a calendar year basis.[37] The PUC based its 3% COLA adjustments on the Social Security Administration's COLA, which is released annually in late fall, and reliance thereon would be consistent with a calendar year adjustment of hourly rates.[38]

In 2008, the PUC found it reasonable to adopt another 3% COLA for intervenor rates for work performed in 2008.[39] That increase is primarily based on various federal inflation indexes, such as the Social Security Administration's COLA and Bureau of Labor Statistics data for consumer prices and wages.[40] In its 2008 Decision and for future reference, the PUC found that a COLA adjustment should be authorized, by future PUC Resolution, for work performed in 2009, and in subsequent years in the absence of a market rate study, to be effective on January 1 of each year.[41]

6.8. DETERMINATION OF MARKET VALUE HOURLY RATE

Fees claimed may be adjusted to reflect Market Rate. "The hearing officer shall issue a written decision that ... shall determine the amount if compensation to be paid, which may be all or part of the amount claimed." 28 CCR § 1010(e)(7). APPLICANT claims advocacy and witness fees for: one non-attorney Program Manager, one Managing Attorney, one Supervising Attorney, and three Staff Attorney & Policy Analysts.

For work performed by APPLICANT's Program Director, APPLICANT claims advocacy and witness fees at hourly rates of $325.00 (for 2004) and $350.00 (for 2006 and 2007). The PUC did not have adopted hourly non-attorney hourly rates for 2004; however, a PUC Decision[42] set forth individually adopted non-attorney rates ranging from $150 to $215 for non-attorney experts with 12 to 16 years of experience, during 2003-2005. The PUC's adopted hourly non-attorney intervenor rate range for 2006 is $115 - $370 without breakdown by years of experience, and for 2007 is $150 - $380 for non-attorney experts with 13 and over years of experience. At the time of the work for which the claim is made and according to the biographical information submitted, APPLICANT's Program Director had more than 25 years of experience in health and human services advocacy and approximately 10 years of experience as APPLICANT's Program Director.

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[37] D.07-01-009 (January 11, 2007) at p. 9.
[38] *Id.* at pp. 4 and 11.
[39] D.08-04-010 (April 10, 2008) at pp. 4 and 24.
[40] *Id.* In reviewing available data, the PUC found no index that specifically targets rates for services by regulatory professionals (attorneys, engineers, economists, scientists, etc.), and the PUC's "findings are weighted heavily to SSA COLA and similar data." *Id.* at p. 4.
[41] D.08-04-010 (April 10, 2008) at pp. 24 -25.
[42] D.06-11-032 (November 30, 2006), pp. 11 – 12.

The highest of the individually awarded PUC rates for 2004 was $215; however, however, there does not appear to be any rate range adopted by the PUC for non-attorney experts for 2004. The $325.00 hourly rate claimed for 2004 is less than 94 percent of the highest of the rates adopted in PUC's rate range for non-attorney experts for services in 2006 (i.e., illustrated by reducing PUC's highest rate for 2006 by 3 percent per year for 2005 and 2004). The highest of the PUC's rates for non-attorney experts for 2006 is $370 and for 2007 is $380. Therefore, it appears that the $325.00 hourly rate claimed for 2004 and the $350.00 hourly rate claimed for 2006 and 2007 by APPLICANT do not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Program Director , the Hearing Officer finds that $325.00 per hour for services provided in 2004, and $350.00 for services provided in 2006 and 2007 do not exceed Market Rate for the services provided in 2004, 2006 and 2007.

For work performed by APPLICANT's Managing Attorney, APPLICANT claims advocacy and witness fees at hourly rates of $345.00 (for 2007) and $365.00 (for 2009). For 2007, the PUC's adopted hourly intervenor rate range for attorneys with 8 – 12 years of experience is $290 - $345. For 2009, the PUC's adopted hourly intervenor rate range for attorneys with 8 – 12 years of experience is $300 - $355.[43] At the time of the work for which claim is made and according to the biographical information submitted, APPLICANT's Managing Attorney had a J.D. degree from the University of California, Los Angeles School of Law, was admitted to the California State Bar Association in 1999, and had approximately eight years of experience primarily in supervisory and managerial positions with APPLICANT. For attorneys with 8 - 12 years of experience, the highest of the PUC's rates for 2007 is $345.00. Therefore, it appears that the $345.00 hourly rate claimed by APPLICANT for 2007 services does not exceed "Market Rate" as defined in 28 CCR § 1010(b). For attorneys with 8 - 12 years of experience, and the highest of the PUC's rates for 2009 is $355. Therefore, the Hearing Officer finds that the hourly rate requested by APPLICANT for services provided in 2009 exceeds Market Rates and therefore will be adjusted. The Hearing Officer finds that $355.00 per hour is consistent with Market Rate for the services provided in 2009. Regarding services provided by APPLICANT's Managing Attorney, the Hearing Officer finds that $345.00 per hour does not exceed Market Rate for the services provided in 2007 and $355.00 per hour does not exceed Market Rate for the services provided in 2009. .

For work performed by APPLICANT's Supervising Attorney, APPLICANT claims

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[43] For work performed in 2009, the PUC ordered that intervenors are not authorized an hourly rate COLA, and hourly rate ranges adopted for 2008 remain in effect. Resolution ALJ-235 (March 12, 2009) at pp. 2-4.

advocacy and witness fees at hourly rates of $260.00 (for 2004) and $270.00 (for 2005). The PUC did not have adopted hourly attorney rates for 2004 and 2005, but instead set hourly rates on a piecemeal basis for each proceeding and each intervenor. At the time of the work for which claim is made and according to the biographical information submitted, APPLICANT's Supervising Attorney had a J.D. degree from the University of California, Berkeley School of Law (Boalt Hall), was admitted to the California State Bar Association, and had approximately six years of experience primarily in supervisory role with APPLICANT. The $260.00 hourly rate claimed for 2004 is less than 94 percent of the highest of the rates adopted in PUC's rate range for attorneys with 5 – 7 years of experience for services in 2006 (i.e., illustrated by reducing PUC's highest rate for 2006 by 3 percent per year for 2005 and 2004). The highest of the PUC's rates for attorneys with 5 – 7 years of experience for 2006 is $280. Therefore, it appears that the $260.00 hourly rate claimed for 2004 and the $270.00 hourly rate claimed for 2005 by APPLICANT do not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Supervising Attorney, the Hearing Officer finds that $260.00 per hour for services provided in 2004, and $270.00 for services provided in 2005, do not exceed Market Rate for the services provided in 2004 and 2005.

For work performed by APPLICANT's Staff Attorney & Policy Analyst #1, APPLICANT claims advocacy and witness fees at an hourly rate of $170.00 (for 2004). The PUC did not have adopted hourly attorney rates for 2004, but instead set hourly rates on a piecemeal basis for each proceeding and each intervenor. At the time of the work for which claim is made and according to the biographical information submitted, APPLICANT's Staff Attorney & Policy Analyst #1 had a J.D. degree from the University of California, Davis School of Law, was admitted to the California State Bar Association, and had approximately two years of experience as an attorney. The $170.00 hourly rate claimed for 2004 is less than 94 percent of the highest of the rates adopted in PUC's rate range for attorneys with 0 – 2 years of experience for services in 2006 (i.e., illustrated by reducing PUC's highest rate for 2006 by 3 percent per year for 2005 and 2004). The highest of the PUC's rates for attorneys with 0 – 2 years of experience for 2006 is $195. Therefore, it appears that the $170.00 hourly rate claimed for 2004 by APPLICANT does not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Staff Attorney & Policy Analyst #1, the Hearing Officer finds that $170.00 per hour for services provided in 2004 does not exceed Market Rate for the services provided in 2004.

For work performed by APPLICANT's Staff Attorney & Policy Analyst #2, APPLICANT claims advocacy and witness fees at hourly rates of $150.00 (for 2005) and $195.00 (for 2006). The

PUC did not have adopted hourly attorney rates for 2005, but instead set hourly rates on a piecemeal basis for each proceeding and each intervenor. At the time of the work for which claim is made and according to the biographical information submitted, APPLICANT's Staff Attorney & Policy Analyst #2 had a J.D. degree from Duke University School of Law, but in 2005 was not yet admitted to the California State Bar. Serving as a legal graduate or law clerk in 2005, this representative provided services for which the CPP awarded fees to APPLICANT at the rate of $150.00. The $150.00 hourly rate claimed for 2005 is less than 97 percent of the highest of the rates adopted in PUC's rate range for attorneys with 0 – 2 years of experience for services in 2006 (i.e., illustrated by reducing PUC's highest rate for 2006 by 3 percent). The highest of the PUC's rates for attorneys with 0 – 2 years of experience for 2006 is $195, which is the hourly rate claimed by APPLICANT for services in 2006. Therefore, it appears that the $170.00 hourly rate claimed for 2005 and the $195.00 hourly rate claimed for 2006 by APPLICANT do not exceed "Market Rate" as defined in 28 CCR § 1010(b). Regarding services provided by APPLICANT's Staff Attorney & Policy Analyst #2, the Hearing Officer finds that $150.00 per hour for services provided in 2005 and $195.00 per hour for services provided in 2006 do not exceed Market Rate for the services provided in 2005 and 2006. That finding of $150.00 per hour for services provided in 2005 is consistent with an award in a previous Decision in which APPLICANT was awarded advocacy and witness fees at the hourly rate of $150.00 for this representative.

For work performed by APPLICANT's Staff Attorney & Policy Analyst #3, APPLICANT claims advocacy and witness fees at hourly rates of $200.00 (for 2007), $205.00 (for 2008), and $242.00 (for 2009). At the time of the work for which claim is made and according to the biographical information submitted, APPLICANT's Staff Attorney & Policy Analyst #3 had a J.D. degree from the University of California, Berkeley School of Law (Boalt Hall), was admitted to the California State Bar Association in December 2006, and had approximately one - two years of experience as an attorney in 2007 and 2008, and approximately three years of experience as an attorney in 2009. The highest of the PUC's rates for attorneys with 0 – 2 years of experience for 2007 is $200, which is the hourly rate claimed by APPLICANT for services in 2007. The highest of the PUC's rates for attorneys with 0 – 2 years of experience for 2008 is $205, which is the hourly rate claimed by APPLICANT for services in 2008. Therefore, it appears that the $200.00 hourly rate claimed for 2007 and the $205.00 hourly rate claimed for 2008 by APPLICANT do not exceed "Market Rate" as defined in 28 CCR § 1010(b). For 2009, the PUC's adopted hourly intervenor rate

range for attorneys with 3 – 4 years of experience is $200 - $235.[44] Therefore, the Hearing Officer finds that the $242.00 hourly rate requested by APPLICANT for services provided in 2009 exceeds Market Rate and therefore will be adjusted. In 2009, this Staff Attorney had 3 years of experience, and therefore, moved into the 3 – 4 years of experience bracket. The Hearing Officer finds that $220.00 per hour is consistent with Market Rate for the services provided in 2009. Regarding services provided by APPLICANT's Staff Attorney & Policy Analyst #3, the Hearing Officer finds that $200.00 per hour for services provided in 2007, $205.00 per hour for services provided in 2008, and $220.00 per hour for services provided in 2009 do not exceed Market Rate for the services provided in 2007, 2008 and 2009.

7. AWARD

APPLICANT is awarded Advocacy and Witness Fees as follows:

Staff / Title	Hours	Rates	Fees
Program Manager			
-- Work in 2004	0.77	$325.00	$250.25
-- Work in 2006	7.5	$350.00	$2,625.00
-- Work in 2007	7.5	$350.00	$2,625.00
Managing Attorney			
-- Work in 2007	0.3	$345.00	$103.50
-- Work in 2009	1.5	$355.00	$532.50
Supervising Attorney			
-- Work in 2004	0.75	$260.00	$195.00
-- Work in 2005	8.12	$270.00	$2,192.40
Staff Attorney & Policy Analyst #1			
-- Work in 2004	15.77	$170.00	$2,680.90
Staff Attorney & Policy Analyst #2			
-- Work in 2005	3.0	$150.00	$450.00
-- Work in 2006	7.36	$195.00	$1,435.20
Staff Attorney & Policy Analyst #3			
-- Work in 2007	67.95	$200.00	$13,590.00
-- Work in 2008	57.4	$205.00	$11,767.00
-- Work in 2009	17.5	$220.00	$3,850.00
TOTAL FEES	-	-	**$42,296.75**

8. ASSIGNMENT OF PROCEEDING

This proceeding was and is assigned to Stephen A. Hansen, Staff Counsel III, as Hearing Officer.

[44] For work performed in 2009, the PUC ordered that intervenors are not authorized an hourly rate COLA, and hourly rate ranges adopted for 2008 remain in effect. Resolution ALJ-235 (March 12, 2009) at pp. 2-4.

FINDINGS OF FACT

1. APPLICANT has satisfied all the procedural requirements necessary to claim compensation in this proceeding.

2. APPLICANT made substantial contributions to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 as described herein.

3. APPLICANT requested hourly rates for its representatives that, as adjusted herein, are reasonable when compared to market rates for persons with similar training and experience.

4. The total reasonable compensation for APPLICANT is $ $42,296.75.

CONCLUSIONS OF LAW

1. APPLICANT has fulfilled the requirements of Health and Safety Code § 1348.9 and 28 CCR § 1010, which govern awards of advocacy and witness compensation, and is entitled to such compensation, as adjusted herein, incurred in making substantial contributions to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and 28 CCR § 1300.67.2.2.

2. APPLICANT should be awarded $42,296.75 for its contribution to Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and 28 CCR § 1300.67.2.2.

AWARD ORDER

1. Legal Services of Northern California, a California corporation dba Health Rights Hotline, is hereby awarded $42,296.75 as compensation for its substantial contribution to the Timely Access regulatory Proceeding Control Nos. 2002-0018, 2005-0203 and 2008-1579 and to 28 CCR § 1300.67.2.2.

2. Payment shall be made within thirty (30) days of the effective date of this decision.

3. This decision is effective thirty (30) days after posting of this decision on the Department's website. 28 CCR § 1010(e)(7) and (8).

Dated: June 3, 2010

Original Signed by:

STEPHEN A. HANSEN
Hearing Officer
Department of Managed Health Care